



**North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Michael Moseley, Director

April 22, 2005

MEMORANDUM

To: Legislative Oversight Committee Members
Commission for MH/DD/SAS
Consumer/Family Advisory Committee Chairs
State Consumer Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Board Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Mike Moseley

**Re: Communication Bulletin #037
Provider Endorsement**



As we have indicated in previous correspondence, with the implementation of the new Medicaid State Plan for Rehabilitation Option services, all providers of Medicaid covered mh/dd/sa services will directly enroll in the Medicaid program through the Division of Medical Assistance. In order to ensure providers have the appropriate qualifications prior to enrollment, we have designed a process that will require providers to be endorsed by the Local Management Entity (LME) as a prerequisite for Medicaid enrollment. Endorsement will be a verification and quality assurance process using statewide criteria.

The attached draft Policy and Procedure for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services provides the framework for endorsement actions by the LME. The policy includes information on the services for which endorsement will be required. All LMEs, with the exception of Piedmont Behavioral Healthcare (Cabarrus, Davidson, Rowan, Stanly and Union Counties) which is now operating under special Medicaid waivers approved by the Centers for Medicare and Medicaid Services (CMS), will follow this statewide policy.



Attached are three standardized documents, the Policy and Procedure for Endorsement, the Application of Endorsement to be submitted by the Provider, and the Agreement (MOA) to be signed by the LME and Provider.

We welcome your questions or comments on these draft policies during the next thirty days. Questions or comments should be referred to Dick.Oliver@ncmail.net by May 21, 2005.

Attachments

cc: Secretary Carmen Hooker Odom
DHHS Division Directors
DMH/DD/SAS Executive Leadership Team
Rob Lamme
Jim Klingler
Dick Oliver
Kaye Holder
Wayne Williams
Richard Slipsky
Carol Duncan Clayton
Patrice Roesler
Coalition 2001 Chair
DMH/DD/SAS Staff



**POLICY AND PROCEDURES FOR
ENDORSEMENT OF PROVIDERS OF
MEDICAID REIMBURSABLE
MH/DD/SA SERVICES**

**North Carolina
Division of Mental Health, Developmental Disabilities, and
Substance Abuse Services**

I. Purpose and Overview

Purpose:

The purpose of the review of qualifications and the endorsement of Medicaid providers is to assure that individuals receive services and supports from organizations that comply with State and Federal laws and regulations and provide services in a manner consistent with the MH/DD/SA Reform State Plan. The endorsement process provides the LME with objective criteria to determine the competency and quality of Medicaid providers. This process does not apply to ICF/MR facilities, hospitals, independent practice settings or groups.

Overview:

For services that are reimbursed by Medicaid, providers must be endorsed by a LME (Local Management Entity) in order to enroll with the Division of Medical Assistance as a Medicaid provider of an Enhanced Benefit service or services. Endorsement is a verification and quality assurance process using statewide criteria and procedures based on the NC Commission on Mental Health, Developmental Disability, and Substance Abuse Services Rules for Endorsement of Providers (10A NCAC 27I.0208) that are currently in draft form (See Attachment 1).

Framework for Establishing Provider Qualifications:

The North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services is responsible for rules establishing the requirements for the endorsement of Enhanced Benefit providers. (Draft rule regarding Endorsement for Providers (10A NCAC 27I .0208). These regulations will include the requirement for endorsing organizations to provide a specific service or services as a provider of Medicaid services to MHDD/SA consumers.

These Policies and Procedures are to be used by all LMEs. If national accreditation bodies require LMEs to apply additional requirements to this process, those additional standards shall be required for that LME. Interpretation of these Policies and Procedures shall reside with DMH/DD/SAS.

Provider organizations that wish to provide and seek reimbursement for Medicaid covered Enhanced Benefit services must enroll directly with the Division of Medical Assistance and are subject to the LME endorsement process. A provider must seek endorsement in the catchment area in which they intend to deliver service and for the particular service they intend to provide. Endorsement is site and service specific and shall be honored by all LMEs. Should a provider that is endorsed by one LME seek to provide services to consumers of other LMEs, those other LMEs shall verify that the provider's endorsement is current and valid before entry into an agreement and making referrals to said provider. Endorsed providers will be subject to a review for re-endorsement by the endorsing LME on a triennial basis.

II. POLICIES AND PROCEDURES FOR ENDORSEMENT OF ORGANIZATIONS AS QUALIFIED MEDICAID PROVIDERS OF ENHANCED BENEFITS

Scope:

- Applies to all LMEs
- Applies to all organizations that wish to provide Medicaid Enhanced Benefit MH/DD/SA services

Policy for Endorsement of Qualified Providers:

LMEs are required to follow policies and procedures specified in this document to ensure statewide consistency of endorsement. If the LME fails to follow the policy as prescribed, providers may initiate an appeal process within 30 days of the alleged breach. (see Appeal, section 10)

As previously stated, endorsement is a process of qualifying a provider to provide a specific Medicaid covered MH/DD/SA service or services. When a provider wishes to provide services additional to those for which the provider has a current endorsement, the provider must request, in writing, and receive endorsement for the additional service (prior to being able to bill for that service). The responsibility resides with the provider to initiate the request for endorsement for the new service. If endorsement for another service is current and valid, the LME shall not review the components of endorsement common to both services, and should only review the provider to assure the provider is qualified to provide the new service. If the endorsement is for a provider that is part of a multi-site provider entity, i.e. a provider organization with multiple service sites, and/or providing multiple services and the larger entity is already endorsed by another, the LME should only verify the currency of the endorsement by the other LME, and then shall only review components of the endorsement checklist which are site-specific or service specific and have not been previously reviewed.

The endorsement process includes

1. Submission of Application (See attached application)

Services may not be authorized until the provider is endorsed and enrolled to provide Medicaid MH/DD/SA services. The first day of the month in which the provider's endorsement application is approved will constitute the earliest possible effective date for both referrals as well as enrollment in Medicaid.

The provider will notify the LME that it intends to provide a service and seek endorsement by scheduling an appointment to initiate the endorsement process at least six weeks prior to the submission of the endorsement application. The endorsement application packet must be submitted with return receipt to the LME in which the provider's service is located. The LME will acknowledge the application via return receipt to the provider or if the application is hand delivered the LME will sign that it was received. Within 10 business days of receipt of the application the LME will notify the provider in writing if the packet is complete or if additional information is required. If additional information is needed the provider will have 5 business days to submit the needed materials to the LME. Upon receipt of the needed materials the LME will evaluate for completeness. If the needed materials are not received within the 5 business day timeline and the provider wants to continue with the endorsement process the LME will return all documents to the provider and the provider must resubmit the entire application packet and restart the process. If the process is restarted by resubmission of the application the providers position in the schedule for on-site review may be impacted (i.e., the LME may have to assign a new date for application submission based on the availability of slots). If the 5 business day timeline is met the LME shall notify the provider that the packet is complete within 2 business days.

2. On-Site Endorsement Review

An on-site endorsement review will be performed by the LME within 20 business days of verification of the completed package. The LME will use the standardized Endorsement Checklists during the on-site review. If in the course of the on-site review the LME discovers areas that, if substantiated by DFS result in Type A violation, could affect the status of the current license, the endorsement process will be suspended until DFS is satisfied that the provider currently meets all licensure requirements and so notifies the LME. The LME must notify DFS within 24 hours of the on-site visit of the areas of concern. The LME will notify the provider by letter within 10 business days following the on-site review regarding the status of the endorsement review:

- A. approved,
- B. pended for plan of correction,
- C. pended for referral to DFS –clock stops until DFS notifies LME, etc.

If the status of the endorsement review is “Pended for plan of correction” because the Provider is unsuccessful in meeting the requirements for endorsement, the notification letter (referenced above) must be certified with a copy to DMH.

3. Provider Failure to Meet Requirements

The provider will be required to submit a corrective action plan within 20 business days of notification to continue the endorsement process. Failure to submit a corrective action plan within 20 business days of notification shall result in a withdrawal of application. Upon receipt of the corrective action plan the LME will have 15 business days to evaluate the information/materials submitted and make an on-site abbreviated review if needed. Once the evaluation and on-site abbreviated review have been conducted, the LME will have 5 business days to notify the Provider if the information/materials submitted are acceptable and the endorsement is approved or if the information/materials submitted are not acceptable. If the provider information/materials are not acceptable, the provider has 20 business days to submit a revised corrective action plan. Upon receipt of the second corrective action plan the LME will have 15 business days to evaluate the information/materials submitted and make an on-site abbreviated review if needed. Once the second evaluation and on-site abbreviated review is conducted the LME will have 5 business days to notify the provider if the information/materials are accepted and the endorsement is approved or if the information/materials submitted are not acceptable. If a provider fails to meet endorsement requirements after the two corrective action plan submissions the application is denied and the provider will be notified by certified letter (copied to DMH) that the provider must wait six months before re-applying for endorsement. If the provider determines that it will re-apply, the provider must initiate the endorsement process by submitting the completed application packet to the LME.

4. Provisional and Full Endorsement

The LME may grant either provisional or full endorsement to a provider applying for endorsement. Provisional endorsement shall be granted when the provider has not previously provided MH/DD/SA services in North Carolina, or if the provider has provided services in North Carolina previously, but has not provided the specific service for which application is being made. Provisional endorsement status may be granted for up to a six month period and may be renewed once for six more months. The LME will contact the provider within 15 business days of the end of the provisional endorsement period to schedule an on-site review for full endorsement which follows the schedule outlined in Section 3.

Should the provider not meet the full endorsement requirements after two six month provisional periods the provider may not re-apply to the LME for six months.

5. Letter of Endorsement or Provisional Endorsement

When a provider is determined to have successfully met endorsement requirements the LME will notify the provider utilizing the standard “Letter of Endorsement” along with the “Agreement Between the Area Authority/County Program and the Provider”. The LME will notify the DMH (within 10 business days) by copy of the letter and the application after the signed agreement between the AA/CP and the Provider has

been returned to the LME. DMH will notify DMA by copy of the Letter of Endorsement along with the application within 2 business days of receipt of the original letter. (See attached standard letter.)

If a provisional endorsement is issued the LME will notify the DMH and the provider utilizing the standard "Letter of Provisional Endorsement" along with the "Agreement Between the Area Authority/County Program and the Provider". The letter will indicate the beginning and expiration date of the provisional endorsement. The LME will notify the DMH by email copy of the letter and the application after the signed agreement between the AA/CP and the provider has been returned to the LME. DMH will notify DMA by email copy of the Letter of Provisional Endorsement along with the application within 2 business days of receipt of the original letter. (See attached standard letter) If an LME provisionally endorses and does not fully endorse, the LME must notify other LME's who may have recognized the provisional endorsement.

Provisional and full endorsement will be contingent upon the receipt of the signed "Agreement Between the Area Authority/County Program and the Provider".

The first day of the month in which the provider's endorsement application is approved will constitute the earliest possible effective date for both referrals as well as enrollment in Medicaid. LME endorsement of the organization is required prior to DMA's enrollment of the provider as a Medicaid provider.

6. Triennial Re-Endorsement Process

Providers shall be reviewed for renewal of endorsement triennially from the effective date of the full endorsement. The responsibility of initiating the re-endorsement process lies with the provider. The re-endorsement process will be conducted every three years and will include a review of any adverse actions or sanction activity and the results of monitoring carried out by the LME as specified in 10A NCAC 27G Section .0600 - .0610. The provider will submit an application packet as noted in #1 of this section. The application packet must be post marked at least six (6) months prior to the expiration date of the current endorsement. All the time frames that applied for the initial endorsement will also apply to the re-endorsement. If the re-endorsement is for a provider that is part of a large entity the large entity will only need to be re-endorsed by one LME and the service specific sites will be re-endorsed by LME service specific reviews. The LME has the option to perform an abbreviated or full re-endorsement review.

Endorsed providers are responsible for notifying the LME in writing of any changes that may affect endorsement status, including but not limited to licensing sanctions, loss of accreditation, provider management, and critical incident involving consumers, (10A NCAC 27G 0603-0604) within 30 days of the change.

7. Withdrawal of Endorsement

Withdrawal of endorsement may be initiated when there is evidence of substantial failure on the provider's part to comply with current rules, including 10 NCAC 26C .0502,

The provider has not satisfactorily addressed within a reasonable time period issues that endanger the health, safety or welfare of the individuals receiving services; or

The provider has been convicted of a crime specified in G. S. 122C – 80; or

The provider has not made available and accessible all sources of information necessary to complete the monitoring processes set out in G.S. 122-C – 112.1; or

The provider has not submitted the required documentation; or

The provider has altered documents to avoid sanctions; or

The provider has not submitted, revised or implemented a plan of correction within the specified timeframes; or

The provider has not removed the cause of a summary suspension of DFS licensure within the specified time frame."

In cases of substantial failure to comply with current rules as noted above the provider's corporate endorsement may be withdrawn and all LMEs will be notified by DMH.

The provider will be notified of the intent to withdraw endorsement via the standard letter “Notice of Intent to Withdraw Endorsement”. The notice/letter will be signed by the Area Director and copied to DMH, and LMEs statewide. (See attached letter) The DMH will issue a recommendation to DMA to disenroll the provider. The DMH will copy the letter to DFS if it is a licensable service.

If the LME is withdrawing endorsement of only one service and will continue to maintain endorsement for other services from the provider the LME will issue the standard letter to the provider and amend the endorsement agreement.

If the provider’s endorsement has been withdrawn there will be a waiting period of six (6) months before the provider can request endorsement for the service that was withdrawn.

The active date of Medicaid payment will stop when DMA pulls the provider number.

8. Agreement

The LME will enter into an Agreement with an endorsed provider. The standard Agreement and Operations Manual will contain uniform forms, provisions, and requirements statewide for all endorsed Medicaid providers.

9. Transition Process

Due to the large number of providers already engaged in providing services for LMEs, DHHS will issue a schedule for the endorsement of providers for each of the MH/DD/SA services. The schedule will include five phases with specific service definitions assigned to each of the phases.

10. Appeals

A provider appeal process begins with a written appeal request to the involved LME and the Division, including the date and detailed description of the disputed action and a request for review. Resolution should be sought with the local LME first. If resolution is not reached at the local level, the appeal may be reviewed by the Division and/or the Office of Administrative Hearings (OAH). The LME is responsible for notifying the Division about the outcome of the appeal at the local level.

- If a **new** provider who has never been directly enrolled with DMA has an appeal concerning an endorsement that was not granted, the provider may not bill for services until the appeal is resolved.
- For any provider who appeals an endorsement that has been withdrawn or not renewed by the LME, direct billing of that Medicaid service will be suspended until resolution of the appeal.

Outcome of each individual appeal process will determine next course of action for the provider or LME, respectively, in regards to payback or the endorsement process.

DRAFT DRAFT DRAFT DRAFT**NORTH CAROLINA PROVIDER ENDORSEMENT APPLICATION**

Organizations that desire to render services to North Carolina eligible Medicaid Recipients must be endorsed by the Local Management Entity in order to complete the Division of Medical Assistance enrollment process. This endorsement application and a copy of the NC Division of Medical Assistance Application for Provider Participation to deliver Community Interventions Services which include MH/DD/SAS Enhanced Benefit Service.

Completed Provider Endorsement documents and attachments should be submitted to the LME in which you are applying to provide services.

Application Date _____

SECTION I: CORPORATE INFORMATION

1. Organization Name (as used for tax reporting purposes):

Federal Tax ID # _____

Organization Address: (Street)

City: _____ State: _____ Zip Code: _____

County: _____ Office Hours: _____

Number of years doing business under this name: _____

Website Address: _____

Has this Organization ever been in business under a different name? Yes ☐ No ☐

If yes, what name? _____

Primary Contact: _____

Primary Contact's Title: _____

Primary Contact's E-mail Address: _____

Telephone: Office: _____ Fax: _____

Mobile: _____ Pager: _____

Executive Director: _____

Clinical/Medical Director: _____

2. Has any owner, director, officer, administrator or staff ever been convicted or charged with a crime other than a minor traffic offense, in any state or country?Yes ☐ No ☐

If yes, please attach an explanation and any supporting documentation.

3. Organization Legal Entity Type:

- | | | |
|--|--|---|
| <input type="checkbox"/> C-Corporation | <input type="checkbox"/> General Partnership | <input type="checkbox"/> Cooperative |
| <input type="checkbox"/> S-Corporation | <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Not for Profit |
| <input type="checkbox"/> Limited Liability Corporation | <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Government |

*Note: If your business/Organization has a filing status as listed above, you must submit a copy of the "Articles" filed with the NC Secretary of State in their entirety.***SECTION II. FACILITY SPECIFIC INFORMATION** – A facility is identified as a service site. If your Organization operates more than one facility, copy and complete this section for each facility.

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

County: _____ Facility Hours: _____

Telephone: _____ Fax: _____

Information about the Facility Director:

Facility Director's Name: _____

Facility Director's Education: _____

Facility Director's Credentials: _____

1. Is this Organization accredited?: (if yes, attach verification of accreditation)

JCAHO:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Years accredited? _____	Expiration Date: _____
CARF:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Years accredited? _____	Expiration Date: _____
COA:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Years accredited? _____	Expiration Date: _____
CQL:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Years accredited? _____	Expiration Date: _____
OTHER:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	

2. Has the Organization ever been sanctioned, placed on probation or lost accreditation or certification status? Yes ☐ No ☐

If yes, attach an explanation of the circumstances and how it was resolved.

3. Is this facility licensed by? (Attach a copy of the license)DFS: Yes ☐ No ☐ license #: _____ State: _____DSS: Yes ☐ No ☐ license #: _____ State: _____Other: Yes ☐ No ☐ Type: _____
license #: _____ State: _____**4. If you are applying to provide a service which does not require licensure, please submit a completed Self Study of Core Rules. Completed Self Study is attached.** Yes ☐No ☐**5. Is this facility staffed and equipped to serve:**Physically Handicapped? Yes ☐ No ☐ Deaf & Hearing Impaired? Yes ☐ No ☐Blind/Visually Impaired? Yes ☐ No ☐ Behaviorally Disruptive? Yes ☐ No ☐Sexually Aggressive? Yes ☐ No ☐Foreign Languages? Yes ☐ No ☐ (Specify) _____**6. LIABILITY INSURANCE:**

	Yes	No
a. Have you ever had a claim against you?	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes", please list the name and amounts of the insurance and disposition.

b. Are there any current, unsettled claims?	<input type="checkbox"/>	<input type="checkbox"/>
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c. Are you aware of any circumstances that may result in a claim or suit?	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

d. Have you ever had a policy cancelled?	<input type="checkbox"/>	<input type="checkbox"/>
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7. Has there ever been any action or investigation against you Or any owner or qualified professional in your Organization relating to (if yes, please attach explanation):

a) license?	<input type="checkbox"/>	<input type="checkbox"/>
b) certification?	<input type="checkbox"/>	<input type="checkbox"/>
c) registration?	<input type="checkbox"/>	<input type="checkbox"/>

12. Coverage: Indicate what arrangements you make to cover consumer emergency situations during nights, weekends, and holidays (skip if you are requesting endorsement for Diagnostic Assessment only):

13. Physician Coverage: Indicate what arrangement you have made or are planning to make to cover your Organization for consumers who need psychiatric evaluation or psychiatric medication.

List psychiatrist/physician who will see your consumers:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

14. Do you have a manmade, natural disaster, or act of God crisis/disaster plan?

☐ Yes ☐ No If yes, please attach.

15. Have you had a corporate endorsement for the provision of MH/SA/DD services in North Carolina? ☐ Yes ☐ No

If yes, by which LME: _____

16. Please check the service(s) for which you are applying for endorsement and those for which you are already endorsed.

SERVICE	APPLYING FOR ENDORSEMENT	ALREADY ENDORSED
Community Support-Adults (MH/SA)		
Community Support-Children/Adolescents (MH/SA)		
Mobile Crisis Management (MH/DD/SAS)		
Diagnostic Assessment (MH/DD/SAS)		
Intensive In-Home Services		
Multisystemic Therapy- MST		
Community Support- CST (MH/SA)		
Assertive Community Treatment Team- ACTT		
Psychosocial Rehabilitation- PSR		
Child and Adolescent Day Treatment (MH/SA)		
Psychiatric Residential Treatment Facility-- PRTF		
Substance Abuse Intensive Outpatient Program		
Substance Abuse Comprehensive Outpatient Treatment Program		
Substance Abuse Non-Medical Community Residential Treatment		
Substance Abuse Medically Monitored Community Residential Treatment		
Inpatient Hospital Substance Abuse Treatment		
Ambulatory Detoxification		
Non-Hospital Medical Detoxification		
Medically Supervised Detoxification/Crisis Stabilization		
Developmental Therapy Services		
Targeted Case Management for Individuals with Developmental Disabilities		
Opioid Treatment (Formerly Narcotic Addiction Treatment)		
Outpatient Treatment		
Partial Hospitalization		
Professional Treatment Services in Facility-Based Crisis Program		

SECTION III. INFORMATION TO BE SUBMITTED

Information included in items (1 through 6) is required at a 100% level in order for the application to be considered for further evaluation and approval.

1. ** Submit an annualized budget and the most recent certified audit or most recent board approved financial statement, if applicable. (Only required for corporate endorsement.)
2. ** Submit written documentation of source of authority through charter, constitution and/or by-laws or articles of incorporation. (Only required for corporate endorsement.)
3. Submit an Organization organization chart. This chart will include any major programs, program heads/supervisors as well as staffing patterns for each service applying for. The chart will also show the Organization's standing committees and their reporting structure as well as any ancillary positions.
4. ** Submit, if an out-of-state Organization, a certificate of authority that shows eligibility to do business in NC (obtained from the secretary of state's office). (Only required for corporate endorsement.)
5. ** Submit, listing of duties of Owner/CEO, if Organization is privately owned. Include qualifications via resume/curriculum vitae. (Only required for corporate endorsement.)
6. ** Submit, list of board of directors (names, titles and contact). Include documentation that includes required qualifications of board members, method to determine a quorum, and officers' length of term. (Sole Proprietors excluded from this item requirement.) (Only required for corporate endorsement.)
7. ** Submit a conflict of interest procedure (required for private, non-profit Organizations). (Only required for corporate endorsement.)
8. Submit a copy of liability insurance or letter of intent from the Organization's proposed insurance carrier that meets the minimum amounts required for the location in which you are applying for endorsement.
9. Submit proof of automobile insurance for company vehicles, and employee (included contracted employees) vehicles that are used to transport consumers.
10. Submit written references that contain the reference person's name, telephone, and e-mail information. References are to obtained by:
 - One from an individual familiar with fiscal operations of the facility. If the Organization is a new business the reference must pertain to the fiscal stability of the board/CEO/Owner to support the company financially.
 - One from an individual familiar with the clinical operations of the Organization. If the Organization is a new business the reference must be obtained from someone familiar with the clinical director's qualifications and abilities.
 - Two from individuals currently receiving services and/or family members. If the Organization is a new business the references must be obtained from individuals involved in the field of disabilities either professionally or through life experience.

** Required for corporate level endorsement not for site and/or service.

AGREEMENT
BETWEEN
_____**(Area Authority/County Program)**
AND
(PROVIDER Corporate Name)
A DIRECT ENROLLED PROVIDER OF ENHANCED MH/DD/SA SERVICES
FUNDED BY MEDICAID

THIS AGREEMENT is made between _____ (herein known as the 'Area Authority/County Program'), and _____, (herein known as the "Provider"), operating under the laws of North Carolina. By means of this Agreement, the Area Authority/County Program is establishing a relationship with Providers of Medicaid covered services. Except as herein specifically provided otherwise, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns. Now, therefore, in consideration of the covenants mutually exchanged, the parties hereby agree as follows.

RECITALS

The Area Authority/County Program and the Provider enter into this Agreement to govern Provider's provision of mental health, developmental disabilities and substance abuse services to individuals referred to it by the Area Authority/County Program.

Area Authority/County Program initially screens individuals seeking or needing mental health developmental disabilities and substance abuse services, and coordinates treatment by provider participants.

Individuals covered by Medicaid who are in need of mental health, developmental disability and substance abuse services, consistent with their right of choice, choose providers for their services from list of provider participants endorsed by the Area Authority/County Program.

Provider represents that it is a direct enrolled, qualified provider of one or more mental health, developmental disabilities and substance abuse services funded by Medicaid who has been so endorsed by an Area Authority/County Program through the North Carolina Department of Health and Human Services ("DHHS").

This Agreement sets forth provisions pursuant to which Provider will provide mental health, developmental disabilities and substance abuse services to individuals who have chosen Provider for such services.

NOW, THEREFORE, the parties agree as follows:

Provider will provide mental health, developmental disabilities and substance abuse services to individuals who have chosen Provider for such services pursuant to and in compliance with the provisions of this Agreement.

Area Authority/County Program will provide access to such services to individuals, as well as quality assurance and monitoring relating to such services pursuant to and in compliance with this Agreement. The term of this Agreement shall be for three (3) years from _____, 200_ through _____, 200_.

ARTICLE I
RIGHTS AND OBLIGATIONS OF THE AREA AUTHORITY/COUNTY PROGRAM

- 1.1 Operations Manual. The Area Authority/County Program shall provide to the Provider a copy of the "Operations Manual". The Provider acknowledges receipt of the Operations Manual by signing this Agreement. If the terms of this Agreement conflict with information contained in the Operations Manual, the terms of the Agreement shall control.
- 1.2 Notification of Applicable Regulations. The Area Authority/County Program shall make available on to Provider copies of or access to all pertinent rules, regulations, standards, and other information distributed by DHHS that are necessary for Provider's performance under the terms of this Agreement. It is Provider's responsibility to access that information. The Area Authority/County Program shall notify Provider of any substantive change in rule or regulation as soon as possible after receipt of the information from DHHS. A list of rules and regulations is part of the Operations Manual.
- 1.3 Monitoring Under Standards. The Area Authority/County Program shall be given full opportunity by Provider to review performance indicators on-site to evaluate compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disability, and Substance Abuse Services (the "Commission"), the Secretary of the Department of Health and Human Services, and applicable law. The Area Authority/County Program has the authority to conduct local monitoring to evaluate compliance with Federal, DHHS, Medicaid, and other applicable rules and statutes (see Operations Manual) and Provider shall cooperate with Area Authority/County Program in such monitoring. The frequency and the intensity of the local monitoring will be in the discretion of the Area Authority/County Program.
- 1.4 Informed Choice of Provider. The Area Authority/County Program provides information to individuals covered by Medicaid regarding their rights to choice of Provider as governed by State and Federal law. The information includes names, contact information and locations of all Providers who have been endorsed by Area Authority/County Program. The parties agree to rely upon DHHS to maintain a website listing all Providers endorsed to provide MH/DD/SA services within North Carolina.
- 1.5 Endorsement of Providers of Medicaid Funded Services. All Medicaid Providers enrolled and in good standing with Department of Medical Assistance and endorsed by the local Area Authority/County Program shall be deemed part of local Provider community. Endorsement (the verification and quality assurance process) of a Provider of Medicaid covered services is a DHHS statewide procedure followed by all Area Authorities and County Programs. The endorsement of a Provider will follow the signing of this Agreement and prior to the enrollment with DMA.
- 1.6 Training and Technical Assistance. The Provider must attend all relevant Orientation Sessions as determined by the LME at no cost to the Provider. The Provider shall attend all mandatory trainings as related to business practices at no charge to the Provider as space permits. The LME reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The LME shall also mandate Provider attendance at selected Clinical Sessions of which the Provider bears the cost, whether LME sponsored or offered by outside parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to Area

Authority/County Program its application of training information received in the delivery of services and in compliance with the provisions of this Agreement.

- 1.7 Screening, Triage and Referral. The Area Authority/County Program will works with community agencies to ensure that individuals can enter the system through many avenues in order to receive timely and effective service. An individual may seek access to the service system by contacting the Area Authority/County Program, Providers or other community agencies. Individuals seeking access to services shall have an initial screening and triage by the Area Authority/County Program (or its contract agent) in order to determine if an MH/DD/SA need exists and ensure appropriate disposition. The Screening, Triage & Referral (STR) staff will complete an initial screening and the STR staff will then contact the provider of choice (or in the absence of consumer preference) an appropriate provider who represents an appropriate consumer-provider match to complete a comprehensive assessment. TTY capability for persons, who have a hearing impairment, and foreign language interpretation, will be provided to the person making the referral or to the individual seeking service for the purposes of receipt of appropriate information for referral of services at no cost where necessary.

ARTICLE II
RIGHTS AND OBLIGATIONS OF DIRECT ENROLLED PROVIDERS OF MEDICAID
COVERED SERVICES

- 2.0 Covered Services. Provider agrees to provide to individuals eligible for such services the Covered Services identified in Attachment A and all addenda in accordance with all requirements set forth or referenced in the Operations Manual and all subsequent revisions.
- 2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider and its agents providing services on its behalf under this Agreement shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by DHHS policy or law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Agreement shall continuously during the term of this Agreement meet all credentialing and privileging/competency standards as described in this Agreement, the Operations Manual or as required by law, policy or regulation.
- 2.2 Service Record Compliance for Enhanced Benefit Providers. Provider shall maintain a Service Record for each Individual served in accordance with the Service Records standards set forth by the state or federal law, regulation or policy and Area Authority/County Program's policies. The original Service Record related to services provided in accordance with this Agreement shall be accessible for review for the purpose of monitoring services rendered, financial audits by third party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by Area Authority/County Program and by State and Federal law, regulation and policy. If for any reason Provider can no longer maintain the Service Record, Provider will contact the Area Authority/County Program staff member responsible for Service Records to facilitate resolution. Upon request, Provider shall provide data about individuals for research and study to the Area Authority/County Program as permitted or required by DHHS and applicable Federal law. Upon request, Provider shall provide Service Records information about consumers referred by the Area Authority/County Program for Quality Assurance and Utilization Management purposes of the Area Authority/County Program.
- 2.3 Rights of Individuals. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of Area Authority/County Program. The Enhanced benefit Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of Area Authority/County Program.
- 2.4 Adverse Selection. Provider shall be prohibited from arbitrarily declining, refusing to serve or ejecting consumers for the covered services under this Agreement. In the event that Provider declines a referral, refuses to serve or ejects a specific consumer, Provider shall give Area Authority/County Program specific reason for the decline, refusal or denial and in all cases except initial denial, comply with the applicable notice requirements of Section 5.10. In all cases of adverse selection, Provider must provide timely reasons and where applicable, notice. Area Authority/County Program may consider information regarding adverse selection in its evaluation of Provider.
- 2.5 Service Coordination. For purposes of this Agreement, "provider participant" shall refer to all service providers to whom the Area Authority/County Program refers consumers. Continuity of care is expected for all individuals served under this Agreement. In an effort to improve the

coordination of supports and services within the Area Authority/County Program's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other provider participants, Carolina Access and other primary care providers for all individuals served under this Agreement. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall endeavor to participate in team meetings and communicate regularly with other providers regarding mutual cases. The primary service provider who engages an Independent Practitioner (a directly enrolled clinician providing outpatient therapy) to serve consumers receiving enhanced benefits will maintain a MOA/or a contract with the Independent Practitioner to ensure care coordination.

- 2.6 Quality Management. Provider of enhanced benefits shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of quality of care, effectiveness and satisfaction with services to the Area Authority/County Program upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and to implement evidence-based practices as defined and adopted by the Department of MHDDSA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process. In keeping with this Agreement, the Provider shall also comply with the Performance Expectations as developed by the Area Authority/County Program and noted in Attachment C.
- 2.7 Clinical Outcome Measures: At a minimum, the enhanced benefit Provider shall complete the NC-TOPPS for the designated populations as well as all other DMHDDSA required outcomes assessments on clients admitted during each calendar quarter in accordance with Department guidelines and any subsequent changes thereto. (See attached Operations Manual). The Area Authority/County Program shall define the guidelines for obtaining and submitting the outcomes data and convey this information to Provider. The appropriate outcome instrument to be used for a specific client will be dependent upon the age and primary disability category of the client and any changes made to these requirements by the Department of Health and Human Services through any outcome transition plan with the Area Authority/County Program.
- 2.8 Incident Reporting. Provider shall report and respond to all client incidents as required under State and Federal law, rules and regulations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of DHHS. (See Operations Manual)
- 2.9 Reports of Regulatory Authorities. Copies of surveys, reviews and/or audits performed by primary accrediting or regulatory authorities of Provider and utilized to confirm operational compliance of Provider and require corrective action on the part of Provider shall be provided to the Area Authority/County Program upon receipt by Provider.
- 2.10 Suspension or Debarment. Provider certifies by signing this Agreement that neither it nor its agents have been suspended or debarred by any applicable governmental authority from conducting any business or activities contemplated by this Agreement whether under current corporate name or any additional name or former name, including the current or former name of a division department, program or subsidiary.
- 2.11 Liability Insurance. Provider, prior to service delivery, shall provide proof of and continuously maintain insurance coverage with a carrier authorized to do business in North Carolina, or maintain equivalent coverage under a self-insurance program that is approved by the North Carolina Department of Insurance. Liability coverage may be on an occurrence basis or claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail

coverage) shall also be provided for a period of not less than three (3) years after the end of the term of this Agreement, or an endorsement shall be provided for continued liability coverage with a retroactive date on or before the beginning of the term of this Agreement or any prior agreement between Provider and Area Authority/County Program.

Provider shall acquire and maintain:

a) Commercial General Liability:

Provider shall maintain bodily injury and property damage liability coverage as shall protect Provider and any approved subcontractor performing work under this Agreement from claims of bodily injury or property damage which arise from operations of this Agreement whether such operations are performed by Provider, any subcontractor or anyone directly or indirectly employed by either. The amounts of such insurance shall not be less than \$1,000,000.00 each occurrence and \$3,000,000.00 in the annual aggregate unless Provider, with prior written approval of Area Authority/County Program, names the Area Authority/County Program as an additional insured, in which case limits of no less than \$1,000,000.00 each occurrence and \$1,000,000.00 in the annual aggregate would be acceptable.

b) Professional Liability (where applicable):

Provider shall maintain such professional liability insurance coverage as shall protect the Provider's from its failure to conform to the professional standard of care required under applicable law and under this Agreement. The limits of liability shall be not less than \$1,000,000.00 per occurrence and \$3,000,000.00 in the annual aggregate. The Organization's professional liability insurance policy shall name the Area Authority/County Program as additional insured. An original, signed, in force Certificate of Insurance for such coverage shall be provided to the Area Authority/County Program upon execution of this Agreement and throughout the duration of this Agreement as insurance expires.

c) Automobile Liability:

Fleet vehicles, privately owned cars or hired cars utilized in the transport of consumers shall be insured against loss in an amount not less than \$500,000.00 bodily injury each person, each accident, and \$500,000.00 for property damage and \$500,000.00 uninsured /under insured motorist; and \$25,000.00 medical payment.

d) Worker's Compensation and Occupational Disease Insurance:

Provider shall meet the statutory requirements of the State of North Carolina for Worker Compensation and Occupational Disease Insurance, currently \$100,000.00 per accident limit, \$500,000.00 disease per policy limit, \$100,000.00 disease each employee limit, providing coverage for employees and owner.

e) Certificates of Insurance:

The Provider agrees to notify the Area Authority by telephone and by providing written notice within five (5) days after receipt of information that the insurance carrier either intends to amend or terminate a policy or has amended or terminated any insurance policy providing the coverage referred to above. If Provider changes insurance carriers during the performance period of this

Agreement, Provider shall provide evidence to the Area Authority within five (5) days. Subcontractors, as part of the approval process by the Area Authority/County Program, must be required by Provider to meet all the insurance requirements of this Agreement, including providing the Area Authority/County Program with certificates of such insurance. Nonetheless, this does not relieve Provider from maintaining full coverage as well. Area Authority/County Program may, in its discretion require Provider to have it as additional insured on any policy of insurance. To be effective, such requirement shall be in a writing signed by Area Authority/County Program.

- 2.12 Federal Requirements. Provider shall comply with all governmental requirements applicable to the services being provided and to its operations, including, but not limited to the Certification Regarding Environmental Tobacco Smoke: Certification Regarding Lobbying: Certification Regarding Drug-Free Workplace Requirements: and Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions.
- 2.13 Clinical Information Data Submission. Providers that are authorized to conduct an assessment of a referred individual will submit all required data elements electronically within 5 calendar days of the last assessment session to the Area Authority/County Program, using the protocol(s) and formats described in the Operations Manual. Provider shall establish review procedures to ensure that a minimum of 90 percent of all elements for each record are complete and accurate and a minimum of 85 percent of all elements for each record are coded as something other than "Other" or "Unknown" within 30 days of first submission. Providers shall submit outcome instruments required by the Department of MH/DD/SAS in an amount, manner and schedule as described in the Operations Manual.
- 2.14 First Responder for Crisis/Emergency. If Provider is delivering a service with defined first responder responsibilities or who are designated in the Person Centered Plan (PCP) shall act as first responder to individuals referred by Area Authority/County Program if and when the individual and/or a member of their support system initiates contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts, shall be referred to Area Authority/County Program's crisis service. Provider shall notify the individual and his/her support system of the process for accessing crisis/emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the eventuality that Provider is not available. Crisis services do not require prior authorization from Area Authority/County Program.
- 2.15 Utilization Management Requirements. Provider shall abide by Medicaid medical necessity criteria, make every reasonable effort to see individuals within immediacy of need time frames (emergency, urgent, routine), seeking authorization prior to service delivery and, provide accurate and thorough information requested so that service provision is not unduly delayed or disrupted. .
- 2.16 Preservation of DHHS Public Funds. Provider shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies. Providers offering mental health and/or substance abuse services on an outpatient basis shall demonstrate good faith efforts to seek and/or maintain membership on major commercial insurance panels, including but not limited to Blue Cross/Blue Shield.

- 2.17 Response to Survivors of Disasters and other Hazards. If designated by Area Authority/County Program, Provider, under the direction of the Area Authority/County Program and in coordination with the local Emergency Management agency(ies) shall deploy behavioral health disaster responders to deliver behavioral health disaster services to survivors and other responders within the counties served by Area Authority/County Program. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/TTY machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g., FEMA Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined that survivors or other disaster responders are in need of longer term mental health, developmental disabilities, and/or substance abuse services, Provider's behavioral health_disaster responders shall refer such persons in need to the Area Authority/County Program or its designee for further assistance.

ARTICLE III
ADDITIONAL PROVISIONS

- 3.1 Health Insurance Portability and Accountability Act (HIPAA). The Provider and the Area Authority/County Program shall comply with current HIPAA privacy and security rules and regulations as in effect from time to time and each party shall provide evidence to the Area Authority/County Program of this compliance upon request as embodied in Attachment B titled Business Associate Agreement. This includes, but is not limited to, the responsibility of each party to determine when it is exchanging non-treatment-related information with the other party or with other entities, in order to obtain or perform a business service related to the performance of this Agreement, and to implement a specific business agreement with the other party or other entity if so. The parties hereto specifically agree to amend this Agreement on a timely basis as necessary to comply with any and all laws relating to privacy and/or security of healthcare information, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR, Parts 160 & 164:HIPAA) and any subsequent modifications thereof.
- 3.2 Confidentiality. Provider and Area Authority/County Program shall protect the confidentiality of any and all individuals and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing services hereunder, except as authorized by the individual, his legally responsible person, or as otherwise permitted or required by law. The Provider and Area Authority/County Program shall, in addition, meet all confidentiality guidelines promulgated by any applicable governmental authority.
- 3.3 Governing Laws. The laws of the State of North Carolina shall govern the validity and interpretation of the provisions, terms, and conditions of this Agreement. Venue over any action arising out of this Agreement shall lie only in the county(s) in Area Authority/County Program's catchment area.
- 3.4 Entire Agreement; Modification. This Agreement, along with the Operations Manual and other standards or documents specifically incorporated herein, constitutes the entire understanding of the parties and this Agreement shall not be altered, amended, or modified except by an agreement in writing, properly executed by the duly authorized officials of both parties.
- 3.5 Dispute Resolution. The parties shall first attempt to resolve any disagreement between them through the DHHS Appeals Process. However, a failure to do so shall not operate as a failure to exhaust administrative remedies.
- 3.6 Invalid Provisions. If any term, provision, or condition of this Agreement is found to be illegal, void, or unenforceable by a court of competent jurisdiction, the rest of this Agreement shall remain in full force and effect. The invalidity or unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision.
- 3.7 Hold Harmless. The Area Authority/County Program and Provider agree to each be solely responsible for their own acts or omissions in the performance of each of their individual duties hereunder, and shall be financially and legally responsible for all liabilities, costs, damages, expenses and attorney fees resulting from, or attributable to any and all of their individual acts or omissions. No party shall have any obligation to indemnify the other, and/or its agents, employees and representatives.

- 3.8 Compliance with Title VI and VII. Provider shall comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990 (ADA), and all requirements imposed by Federal regulations, rules, and guidelines issued pursuant to these Titles for both personnel employed and individuals served.
- 3.9 Independent Contractor. This Agreement is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between Provider and Area Authority/County Program, their employees, partners, or agents, but rather is an agreement by and among independent contractors; provided this shall not be construed to preclude Provider from utilizing service agreements for provision of professional services in place of employment agreements.
- 3.10 Subcontracting. Provider shall not subcontract or assign any of the services contemplated under this Agreement without obtaining prior written approval from the Area Authority/County Program. Any approved subcontracts or assignments for program delivery shall be subject to all conditions of this Agreement.
- 3.11 Non-Exclusivity. This Agreement is not exclusive. Area Authority/County Program and Providers have the right to enter into a similar agreement with any other area authority/county program and/or other providers at any time.
- 3.12 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Provider shall be responsible for notification to the Department of Facility Services and to Area Authority/County Program of all such changes when required to do so. Each party shall promptly notify the other in writing regarding any merger, name change, acquisition of another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Agreement. Area Authority/County Program/County Program may terminate this Agreement in its discretion if Provider is acquired, merged or experiences a change in ownership or control.
- 3.13 Conflict of Interest. Provider and Area Authority/County Program will comply with all applicable law regarding Conflict of Interest.
- 3.14 Coordination of Benefits. Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that Federal, state and local funding shall be used only if and when other sources of first and third party payment have been exhausted. Providers shall make every reasonable effort to verify all insurance and other third party benefit plan details during first contact, so that persons are directed to appropriate Providers and to comply with North Carolina law. Where available Provider is required to bill a consumer's private insurance. During an emergency, Provider shall provide the necessary services and then assist to coordinate payment.
- 3.15 Response Time. Provider shall implement policies, procedures, performance standards and monitoring and shall consistently provide adequate staffing and scheduling to ensure compliance with the Department of MH/DD/SAS Services' "immediacy of need protocol", such that: 1. Individuals in emergency status, meaning a situation which threatens the health, safety or welfare of the Individual and/or of others, shall result in a face-to-face assessment which shall commence no later than two hours from notification to either party, 2. Individuals in urgent status, meaning their situation is likely to escalate into an emergency, must be seen face-to-face within 48 hours of first notification, and 3. Individuals with routine needs must be seen face-to-face (assessment and /or services) within seven (7) calendar days of first notification.

ARTICLE IV
TERM AND TERMINATION

- 4.1 Term: The term of this Agreement shall be for a three-year period commencing.
- 4.2 Voluntary Termination. This Agreement may be terminated at any time upon the mutual consent of both parties or after thirty (30) days upon written notice of termination by one of the parties.
- 4.3 Involuntary Termination. Either party may immediately terminate this Agreement with cause. The cause for termination shall be documented in writing presented to the other party detailing the grounds for termination.
- 4.4 Notice: Either party may at any time change its address for notification purposes by mailing a notice to the other party at the address designated by that party. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10th) day following the date such notice is received.
- 4.5 Option for Limited Renewal: The Area Authority/County Program may, by written notice to the Provider executed by the Area or Program Director, extend the term of this Agreement by three (3) months.

Provider name/ address

Federal ID No. _____

By _____ **DATE** _____

Title _____

—

Area Authority/County Program name/address

DULY AUTHORIZED OFFICIAL

DATE

ATTACHMENT A
(Each Area program designs)

SCOPE OF SERVICES

(Provider Name)

ATTACHMENT B

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made effective the **1st of July 200-**, by and between Provider, hereinafter referred to as “Covered Entity” and Area Authority/**County Program** hereinafter referred to as “Business Associate”, (individually, a “Party” and collectively, the “Parties”).

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as “the Administrative Simplification provisions,” direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the “HIPAA Security and Privacy Rule”); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a “business associate” of Covered Entity as defined in the HIPAA Security & Privacy Rule (the agreement evidencing such arrangement is entitled **Purchase of Service Agreement** dated **July 1, 200-** and is hereby referred to as the “Arrangement Agreement”); and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Privacy Rule, as amended, the HIPAA Security & Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security & Privacy Rule, but are nonetheless permitted by the HIPAA Security & Privacy Rule, the provisions of this Agreement shall control.

The term “Protected Health Information” means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mh/dd/sa or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the

individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.

II. CONFIDENTIALITY REQUIREMENTS

- (a) Business Associate agrees:
 - (i) To use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Security & Privacy Rule), or the HIPAA Security & Privacy Rule, and (3) as would be permitted by the HIPAA Security & Privacy Rule if such use or disclosure were made by Covered Entity;
 - (ii) At termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of covered entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and
 - (iii) To ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information and agrees to implement reasonable and appropriate safeguards to protect any of such information which is electronic protected health information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.
- (b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:
 - (i) If necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:
 - (A) The disclosure is required by law; or

- (B) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;
 - (ii) for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the protected health information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.
- (c) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic protected health information that it creates, receives, maintains, or transmits on behalf of covered entity as required by the HIPAA Security and Privacy Rule.
- (d) The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Security & Privacy Rule.
- (e) Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to covered entity any security incident of which it becomes aware. For purpose of this agreement Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

III. AVAILABILITY OF PHI

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security & Privacy Rule. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Security & Privacy Rule. In addition, Business Associate agrees to make Protected Health Information

available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Security & Privacy Rule.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate of such belief within a reasonable time after forming such belief, and Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressly DHHS herein or the HIPAA Security & Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the DHHS of North Carolina. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Security & Privacy Rule, such party shall notify the other party in writing. For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Security & Privacy Rule, then either party has the right to terminate upon written notice to the other party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:

BUSINESS ASSOCIATE:

By: _____

By:

Title: _____

Title:

ATTACHMENT C

PERFORMANCE INDICATORS FOR PROVIDERS OF MH/DD/SA SERVICES

1. Providers shall be responsible for full participation in an Area Authority/County Program monitoring/review process that includes the Department of MH/DD/SA Confidence Assessment Criteria, and the Local Monitoring discussion guide. Frequency of reviews and corrective requirements are determined by demonstration of acceptable compliance with quality indicators and scores from the Confidence Assessment.
2. 100% of all Level I Incidents as defined by the NC Department of MH/DD/SAS shall be recognized, adequately responded to, and reported/documented internally by the Provider, and reported in aggregate form quarterly to the Area Authority/County Program.
3. At least 75% of all Level II Incidents as defined by the NC Department of MH/DD/SAS shall be recognized, adequately responded to, and reported to the Area Authority/County Program and Department within 72 hours via the *DHHS Incident & Death Form*. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.
4. At least 75% of all Level III Incidents as defined by the NC Department of MH/DD/SAS shall be recognized, adequately responded to, and reported verbally immediately to the Area Authority/County Program, and in written form to the Area Authority/County Program and Department within 72 hours via the *DHHS Incident & Death Form*. The Provider shall convene an incident review committee within 24 hours. Deaths that occur within 7 days of seclusion or restraint are reported immediately to the Area Authority/County Program. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.
5. Providers shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. 100% of all substantiated client rights violations shall be reported through the Incident reporting process to the Customer Services/Consumer Affairs Unit of the Area Program/County Program Quality Management Department, and show evidence of being acted upon. -
6. 100% of quality of care issues, as noted through Area Authority monitoring, shall promptly begin to be addressed through the development and initiation of a corrective action plan submitted for approval to the Area Authority/County Program within the time limits specified in the Area Authority/County Program's Quality Management Plan.

7. A representative sample of consumers shall be given the opportunity to express their *perception of satisfaction* for services received through the implementation of an empirical process no less often than twice a year. Survey results are submitted to the Area Authority. Providers may meet this requirement by full participation in the Area Authority/County Program's Quarterly Consumer Satisfaction Survey. The Provider is also required to participate in the Department's annual Consumer Satisfaction Survey.
8. When applicable...Providers shall meet no less than -85% with established time frames for initial face-to-face consumer contact (Emergent: within 2 hours; Urgent: within 48 hours; Routine: 7 calendar days.).
9. Providers shall meet 100% compliance with Operations Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS, COIs, NC-SNAP). As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers & families).
10. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the Area Authority/County Program in any quarter of completion.

Operations Manual

DRAFT 4/7/05

(insert name)
Area MH/DD/SAA

DRAFT

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- Medicaid Provider - www.dhhs.state.nc.us/dma
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- State Funded - Attach AA/CP policies/procedures
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- www.dhhs.state.nc.us/mhddsas/manuals/forms/dhhs-incident11-18-04

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OPERATIONS MANUAL

INTRODUCTION

This manual is a binding part of the Agreement or contract between the Area Authority and providers of Medicaid and State Funded services. The intent of this manual is to reference detailed information and where possible require the same statewide procedures as part of any agreement or contract between a Area Authority/County Program and a provider agency.

This manual does not include information about DHHS endorsement procedures that take place prior to any agreement with a Medicaid Provider. Rather, it includes only information pertinent to the performance of the Agreement or contract, whichever applies.

Information or procedures which pertain only to Medicaid providers or only to State Funded providers are identified. The absence of this designation Medicaid or State Funded means that the information or source document pertains to both types of providers. References to the Area Authority/County Program policy and procedures mean that the local LME may insert their own information and that statewide applications do not apply at this time.

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SECTION I
Provider Relations

- Medicaid Provider - www.dhhs.state.nc.us/dma/mp/mpindex.htm
- State Funded Provider(GS 122C-151.4) AA/CP policies/procedures

Problem Resolution/Disputes and Appeals: *If problems arise between the Provider and the Area Authority in the delivery of services, the parties shall attempt whenever possible to resolve these problems informally in a reasonable and timely manner. In the event that informal resolution is not appropriate or is unsuccessful, the process outlined in GS 122C-151.4 shall be followed.*

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Technical Assistance/Training Collaboration: Reference section of State Funded Contract – Article I – 1.5 and Medicaid Funded MOA – Article I – 1.6.

(insert Area Authority specific information)

- Medicaid Provider – DMA website www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider – AA/CP format

Who to Contact for Questions

(modify list as needed and insert Area Authority-specific contact information-names, numbers and e-mails of contacts are recommended)

Agreement Questions

Monitoring Questions

Credentialing/ Privileging
Accreditation
Licensure

Liability Insurance

Authorizations

Invoices

Payment

Medical Records

Quality Assurance

Clinical Concerns

-PCP

-

- Medicaid Provider - (USE DMA Forms) www.dhhs.state.nc.us/dma/form – html#prov
- State Funded Provider – Area Program form

Notification of Change of Address: *Formal notification of change of address of either party shall be given to the other.*

(Insert procedures/form for Provider to notify Area Authority and Area Authority to notify Provider of address changes)

Section II

Comprehensive List of State and Federal Requirements for The Area Authority and Provider

The document below serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement. These documents change based on legislative action, change in federal and state policy, and state procedures. There is a mutual responsibility for Providers and Area Authorities to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if an Area Authority has concerns about how a change will be implemented, then the Area Authority shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the Area Authority for information. If a Provider has problems obtaining or understanding the information referenced in this section, please contact the following department/individual at the Area Authority:_____.

**Comprehensive List of State and Federal Requirements for
The Area Authority and Provider**

REQUIREMENT	SUGGESTED ACCESS	WEB SITE, IF AVAILABLE
APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) APSM 45-1 (Confidentiality) APSM 45-2; 45-2a (Service Record Manual) APSM 95-2 (Client Rights) APSM 10-3 (Records Retention and Disposition Schedule) APSM 75-1 (Retention of Financial Records)	Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294	Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance www.dhhs.state.nc.us/mhddsas/manuals
CAP-MR/DD Manual –(CAP Providers and Core Competencies Training Requirements for MR/MI service providers)	Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294	http://www.dhhs.state.nc.us/mhddsas/developmentaldisabilities/operations/index.htm
Medicaid-Related Documents Medicaid-covered services definitions Medicaid Services Guidelines Medicaid Communiqués	Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294	http://www.dhhs.state.nc.us/mhddsas/medicaid/index.htm
-	-	-
Residential Licensure Requirements	(919) 855-3750	http://facility-services.state.nc.us/provider.htm
Health Care Personnel Registry	(919) 733-8500 or (919) 715-0562	http://facility-services.state.nc.us/hcarpage.htm and www.ncnar.org
SB 163- Monitoring of Providers		http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm

State Level		
<p style="text-align: center;">General Statutes</p> <p>122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985</p> <p>Applicable sections include but are not limited to:</p> <ul style="list-style-type: none"> ▪ 122C-3 Definitions ▪ 122C-4 Use of phrase “client or his legally responsible person ▪ 122C-51 Declaration of Policy on clients rights ▪ 122C-52 Right to confidentiality ▪ 122C-53-56 Exceptions... ▪ 122C-57 Right to treatment and consent to treatment ▪ 122C-58 Civil Rights and civil remedies ▪ 122C-59 Use of Corporal punishment ▪ 122C-60 Use of physical restraints or seclusion ▪ 122C-61 Treatment rights in 24-hour facilities ▪ 122C-62 Additional rights in 24-hour facilities ▪ 122C-63 Assurance for continuity of care for individuals with mental retardation ▪ 122C-64 Human rights Committees ▪ 122C-65 Offenses relating to clients ▪ 122C-66 Protection from abuse and exploitation; reporting ▪ 122C-67 Other rules regarding abuse, exploitation, neglect, no prohibited ▪ 122C-(116,141,142,146) Local Government Entity ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc ▪ 90-21.4 Treatment of Minors ▪ 7A 517, 452-553 Abuse and neglect of Minors ▪ 108A 99-111 Abuse and Neglect of Disabled Adults ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc. 		<p>All of the NC general statutes can be located on-line at the following site. Just type in the statute number you wish to review in the search box that is in this site.</p> <p>www.ncleg.net</p>
DHHS Disaster Preparedness, Response and Recovery Plan		(Not yet available)
SB 926- Monitoring of Providers		http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm
Performance Agreement(03-04) between DMH and Area programs-Attachment 12-prompt pay		www.dhhs.state.nc.us/mhddsas/performanceagreement
Contract between the Area Authority and the NC division of MH/DD/SAS		http://www.dhhs.state.nc.us/mhddsas

Federal level		
Drug Free Workplace Act of 1988 as revised	Library-Federal Laws	http://www.dol.gov/elaws/drugfree.htm
Section 503 and 504 of the Rehabilitation Act of 1973	Library –Federal Laws	http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eeo
Civil Rights Act of 1964	Library-Federal Laws	www.eeoc.gov http://www.eeoc.gov/policy/vii.html
Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16	Library-Federal Laws	www.dol.gov
Public Law 99-319, May 1986 Protection and Advocacy for Mentally Ill Persons	Library-Federal Laws	http://thomas.loc.gov/bss/d099/d099laws.html Search for 99-320
<ul style="list-style-type: none"> ▪ Title I Protection and Advocacy Systems ▪ Title II ReinStatement of Rights for Mental Health patients 		http://www4.law.cornell.edu/uscode/42/ch114.html
Public Law 100-509 Protection & Advocacy for Mentally Ill Individual Amendments Act of 1988, October 1988	Library-Federal Laws	http://thomas.loc.gov/bss/d100/d100laws.html Search for 100-509 http://www.oxfordhouse.org/fairhouse.html
Public Law 101– 496 Developmental Disabilities Assistance and Bill of Rights Act of 1990	Library-Federal Laws	http://thomas.loc.gov/bss/d101/d101laws.html Search for 101-496
42 CFR Part 2 Confidentiality Regulations 45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information	Library-Federal Laws	Federal Regulations search: http://www.gpoaccess.gov/cfr/index.html
Office of the Inspector General (Exclusions - “Lower-tier Transactions and disbarment”)	Library – Federal Laws	http://oig.hhs.gov/fraud/exclusions.html
Pro-children Act Section 1041-1044 of the Educate America Act of 1994 prohibiting smoking in areas used by children.	Library – Federal Laws	http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html
Americans with Disabilities Act	Library – Federal Laws	http://www.usdoj.gov/crt/ada/adahom1.htm
OTHER		
North Carolina Council of Community MH/DD/SAS Programs		www.nc-council.org
Area Authority/LME -Specific		
Local Business Plan		(fill in)
Local Policies and Procedures		(fill in)
		(additional as needed)

Section III
Authorization Process

- Medicaid Provider - www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider - Attach AA/CP policies/procedures

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AA/CP – Policy and Procedure will designate practices to be used by State Funded Providers.

Section IV

Claims

(Expand each section as needed)

- State Funded Provider - Attach AA/CP policies/procedures

Area Authority/LME Fee Collection Policy and Minimum fee/sliding scale fee schedule:

- Medicaid Provider - www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider- Attach AA/CP policies/procedures

Claims Filing Requirements: *(include reminder that providers must bill for third party payment when information regarding such information is available. Include how this information will be made available by the LME and/or how the provider is to ensure and verify all available information is obtained and accurate either directly from the consumer or from the LME).*

- State Funded Provider- Attach AA/CP policies/procedures

Electronic Connectivity Requirements:

- State Funded Provider- Attach AA/CP policies/procedures

Payment Schedules:

(IPRS Check write schedule, other schedules)

- State Funded Provider- Attach AA/CP policies/procedures
- Medicaid Provider DMA website www.dhhs.state.nc.us/dma/home.htm

Claims Adjudication:

- State Funded Provider– Reference Contract - Attachment III 1.7.1

Prompt Pay:

(-Attachment 16 from 03-04 Performance Agreement--

Section V
Provider Documentation Submission Requirements

- Medicaid Provider - www.dhhs.state.nc.us/dma/provenroll.htm
- State Funded Provider– AA/CP policies/procedures

Section VI

Quality Improvement and Performance Monitoring

(It is recommended the Area Authority be respectful of the limits on Provider's time given that Providers are operating in a fee-for-service environment, and therefore request performance of non-reimbursable activities judiciously).

Provider Monitoring:

(Address Area Authority surveys; QA reviews and SB163 monitoring; reporting on performance indicators)

- www.dhhs.State.nc.us/mhddsas/manuals/aps/apsm95-2clrights7-03

Client Rights Reporting:

(Insert Area Authority-specific procedures for reporting client rights activities)

- www.dhhs.state.nc.us/mhddsas/manuals/forms/dhhs-incident11-18-04

Incident Reporting: *All incidents pertaining to Area Authority clients shall be reported to the Area authority and NC DHHS as required in APSM 95-2(Client rights) and APSM 30-1 (Quality Assurance/Improvement), and 10A NCAC 27G.0600. [NOTE: there's also a form (DHHS Incident and Death Form) and manual for incident report at <http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm>]*

(Insert Area Authority-specific procedures for incident reporting)

Person-Centered Planning: Communication Bulletin #34

(Since these will be new and lengthy it is recommended to insert content or at least links to each section on a website-Area Authority's or Division's- when formally adopted by the Division)

Clinical Outcome Measures:

(This section should include any requirements for clinical outcome measures which at minimum must include information about the Division required client personal outcome instruments that the provider is required to complete-which instrument is completed on who and when, and then your Area Authority-specific requirements regarding sampling and submitting the information to the Area Authority. A reference should also be made that the Division will be requiring all MH/SA clients ages six and older to use the expanded NC TOPPS system at an agreed upon time with the LME during the fiscal year and that they will be informed of this when the effective date is known).

NC-TOPPS: Communication Bulletin forthcoming at www.dhhs.state.nc.us/mhddsas/announce/index.htm

– also <http://nctopps.ncdmh.net/>

Section VII

-State Funded Providers-Area Authority Specific Policies/Forms/Local Governance Requirements

(not included elsewhere-can also insert link to these on Area Authority website)

Section VIII

Glossary of Terms

(Division's-any area Authority/LME additional terms should be added)

Definitions included in this section are primarily for clarification of terms used in the body of this Agreement, its attachments and manual. However many of these definitions are also used in existing state and Area Authority documents and are included here to be helpful but are not to be considered comprehensive. Where similar definitions apply to multiple terms, the terms are grouped. Broad categories are defined with specific elements detailed as a part of the entire definition.

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION – Certification by an external entity that an organization has met a set of standards.

ACT-Assertive Community Treatment

ADULT- means a person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies.

ADMINISTRATIVE SERVICES- means the services other than the direct provision of MH/DD/SA services (including case management) to eligible or enrolled persons, necessary to manage the MH/DD/SA system, including but not limited to: provider relations and contracting, provider billing accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representative of the Contractor at Administrative hearings concerning the Contractor's decisions and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality management.

ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field.

AOC - Administrative Office of the Courts.

APPEAL- means a formal request for review of a decision made by the Contractor or a subcontracted provider related to eligibility for covered services or the appropriateness of treatment services provided.

APPEALS PANEL - The State MH/DD/SA appeals panel established under NC. G.S.

371.

ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.

AUTHORIZATION - The process by which Utilization Management agrees to a medically necessary specific service or plan of care based upon best practice. The granted request of a provider is assigned a number for tracking and linked to the subsequent claim that will be made for reimbursement. *PRE-AUTHORIZATION/PRIOR AUTHORIZATION* is the process of approving use of certain resources in advance rather than after the service has been requested. Approval for admission to hospitals in an emergent situation is one example. *RE-AUTHORIZATION* is the process of submitting a request for services for a consumer who has already received authorized services. The request shall specify the scope, amount and duration of service requested and shall indicate the consumer's progress toward outcomes, the use of natural and community supports, and how the requested services will support the outcome the individual is seeking. *RETROSPECTIVE AUTHORIZATION* is authorization to provide services after the services have been delivered.

BASIC SERVICES – Mental health, developmental disability or substance abuse services that are available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.

BENEFIT PACKAGE OR PLAN – An array of treatments, services and/or supports intended to meet the needs of target or priority populations. *BENEFIT LIMITATIONS* are any provision, other than an exclusion, which restricts coverage, regardless of medical necessity. *Covered Benefits* medically necessary services that are specifically provided for under the provisions of Evidence of Coverage. A covered benefit shall always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered. **BEST PRACTICE (S)** – Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, *EVIDENCE-BASED*, or *RESEARCH-BASED* may also be used.

BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. Also referred to as *CATEGORICAL FUNDING*.

CARE COORDINATION – The methods utilized to notify other providers of significant events in the course of care and to enable multiple providers to give integrated care to an individual. Professionals with a broad knowledge of the resources, services and programs supported by the public MH/DD/SA system and the community at-large advocate for access and link individuals to entitlements and services. It is an administrative Service Management Function performed by the Contractor for individuals not enrolled or not meeting target population definitions.

CARF - Council on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the State served by a specific Contractor. The *GEOGRAPHIC AREA* can be a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide covered services to eligible residents of their area.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

CERTIFICATION – A Statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. The Contractor or the NC Council may be the certifying agency for subcontracted **Providers**.

CFAC - Consumer and Family Advisory -Committee

CHILD-means an eligible person who is under the age of 18, unless the term is given a different definition by statute, rule or policies.

CLAIMS MANAGEMENT – The process of receiving, reviewing, adjudicating, INVESTIGATING, paying, and otherwise processing service claims submitted by network and facility providers. *CLAIM* – An itemized Statement of services, performed by a provider network member or facility, which is submitted for payment. *CLEAN CLAIM*- means a claim that successfully passes all adjudication edits. **CLIENT** - An individual who is admitted to or receiving public services. “Client” includes the client’s personal representative or designee and the terms *CONSUMER*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CLIENT OUTCOMES INVENTORY (COI) – DMH/DD/SAS measurement system for assessing treatment/services outcomes of mental health and substance abuse service consumers.

CLIENT DATA WAREHOUSE - The DHHS’s source of information to monitor program, clinical and demographic information on the clients served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.

CLINICAL PRACTICE GUIDELINES – Utilization and quality management mechanisms designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The guidelines or *TREATMENT PROTOCOLS* are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups. NC has adopted protocols for MH and DD. NC uses ASAM Guidelines for substance abuse.

COA -Council on Accreditation

CO-MORBID CONDITION- CO-OCCURRING DISORDERS, DUAL DIAGNOSIS –

Terms that reflect the presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions, etc and require specialized approaches.

COMPLAINT – A report of dissatisfaction with some aspect of the public MH/DD/SA system. The term *DISPUTE* is used to indicate a specific complaint about a service or a provider that requires attention and joint resolution.

CONFLICT OF INTEREST – A situation where self interest could negatively impact the best interests of the person being served or the system.

CONSENSUS - Majority opinion regarding a group decision. It is not the same as total agreement.

CONSUMER- An individual who is admitted to or receiving public services. “Consumer” includes the consumer’s personal representative or designee and the terms *CLIENT*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CONSUMER/FAMILY ADVISORY COMMITTEE – A Board appointed group of persons receiving services, families of persons receiving services, advocates and other stakeholders that participate in meaningful decision making relative to the local program. The group shall meet at least monthly in a public forum to review data, practices, policies and plans of the Contractor and make recommendations to the Board from the consumer/family perspective.

CONTRACT- A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is time limited. A contract is defined as a document that governs the behavior of a willing buyer and a willing provider. In this case the Contract is the 2004 Performance Agreement between the Department and the LME.

CONTRACTOR - an organization or entity agreeing by signature to provide the goods and services in conformance with the Stated contract requirements, NC statute and rules and federal law and regulations.

CONTRACT YEAR-a period from July 1 of a calendar year through and including June 30 of the following year.

COPAYMENT- The portion of the cost of services which the enrolled person pays directly to the Contractor or the subcontracted providers at the time-covered services are rendered.

CORE SERVICES – *BASIC SERVICES* such as screening, assessment, crisis or emergency services available to any person who needs them whether or not they are a member of a target or priority population. The term also includes universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders. **CORPORATE COMPLIANCE** – The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

CREDENTIALING – The process of approving providers for membership in a network to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

CRISIS – Response to internal or external stressors and stressful life events that may seriously interfere with or compromise a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself. *CRISIS RESPONSE* is the immediate action to assess for acute MH/DD/SA service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate services. These services are available 24 hours per day, 365 days per year. These services may be referred to as *EMERGENCY* services as well. NC requires a *CRISIS PLAN* for consumers to promote recovery and to lessen the trauma of emergency events. **CULTURAL**

COMPETENCE/PROFICIENCY – A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing that we accept and value others even when we may disagree with them.

CUSTOMER – Customers may be *ULTIMATE CUSTOMERS* who are the intended and actual recipients of the services provided by the public system, *INTERNAL CUSTOMERS* are those individuals internal to the system who rely on each other to provide the service to the ultimate customer; and *EXTERNAL CUSTOMERS* are those groups and individuals outside the system that have a take in the outcomes and products produced by the system. The concept is critical to proper implementation of

DD - Developmental Disability

DEFAULT – The breach of conditions agreed to in this Contract and/or failure to perform based upon defined terms and conditions the scope of work specified in the Contract.

DE-INSTITUTIONALIZATION – Release of people from institutions to care, treatment and supports in local communities. De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in *OLMSTEAD V. LC* has given new momentum to development of community based services for individuals who have remained in State hospitals and mental retardation centers because community services were not available. This movement is often referenced as movement to least restrictive care or to lower levels of care where safety and community integration are balanced and supported through the community system of services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees State government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DHHS- Department of Health and Human Services.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders.

DISASTER – A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress, and economic loss. Disasters result in situations that call for a coordinated, multi-agency response. A disaster calls for a response and resources that usually exceed local capabilities.

DIVERSION – Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a State hospital. The term is also used when preventing arrest or imprisonment by providing services that restore functioning and avoid detention. In North Carolina diversion programs are in place in response to SB859 that prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North

Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DJJDP - Department Of Juvenile Justice and Delinquency Prevention.

DOMAINS - Major areas of concern to the NC public MH/DD/SA system and its mission, goals, and strategies and for which indicators and measures are developed to examine outcomes of service in the lives of people served.

DPI -Department of Public Instruction

DSS - Department of Social Services

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

(EPSDT) – Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. Education and training are also activities or programs delivered to staff to ensure that service providers are competent to provide services identified as best practices.

ELIGIBILITY – Determination of the service and/or benefit package an individual may be entitled to or determination of a class membership that allows entry to certain services and supports. The determination that individuals meet prescribed criteria for a particular program, set of services or benefits.

EARLY INTERVENTION - The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.

EMERGENCY- Means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply: o The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. o The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing or ambulating, and this inability may lead in the near future to harm to the individual or to another individual. o The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

ENROLLED – Individuals are admitted for service and have been provided at least one service and assigned a unique identifying number.

FAIR HEARING RIGHTS – Advance and Adequate Notice - The Contractor notice in accordance with DHHS policy and procedure using prescribed forms when denying, reducing, suspending or terminating covered services that require prior authorization. The Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by State and federal law and regulations. **FEE FOR SERVICE** – A method of payment for health care. A payer pays the Contractor or a service provider for each reimbursable treatment, upon submission of a valid claim, and according to agreed upon business rules. The *FEE SCHEDULE* is a list of reimbursable services and the rate paid for each service provided.

FEMA - Federal Emergency Management Agency

FORENSIC – Term used to describe a person with mental illness, developmental disability or substance abuse who is involved in the criminal justice system. This includes persons found Not Guilty by Reason of Insanity (NGRI), those who are Incompetent to Stand Trial, or who are in jails or prisons or referred to the mental health system by criminal courts for evaluation and treatment.

FORMULARY – A list of drugs that are considered preferred therapy for a given condition and cost effective and are to be used by providers in prescribing medications. **FUNCTIONAL OUTCOMES** - The extent to which individuals receiving services and supports reach their goals. These outcomes generate from *DOMAINS* as defined earlier related to desirable life developments that all people wish to achieve, such as safe and affordable housing, employment or a means of support, meaningful relationships, participation in the life of the community, etc.

GAPCD - Governor's Advisory Council for Persons with Disabilities

GENERAL FUND – State funds used by the General Assembly for public programs and initiatives.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area. The Contract standard is 30 minutes/30 miles.

GRIEVANCES – A formal complaint by a service recipient that shall be resolved in a specified manner detailed in this Contract.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, State, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) –Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper-based, and mandates "best effort" compliance.

HIPAA - Health Insurance Portability and Accountability Act

HUD - Housing and Urban Development

HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to rights violations guaranteed by law and under this contract.

INCURRED BUT NOT REPORTED (IBNR)- means liability for services rendered for which claims have not been received. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. Failure to account for these potential claims could lead to inaccurate financial estimates.

INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.

IPRS-Integrated Payment Reporting System

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) –Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LBP - Local Business Plan

LEAST RESTRICTIVE CARE – The service that can be provided in the most normative⁴ setting while insuring the safety and well being of the individual.

LENGTH OF STAY (LOS) – The amount of time that a person remains in a service program, including hospitals, expressed in days.

LEVEL OF CARE (LOC)- A structured system for evaluating acuity and *INTENSITY OF NEED* against the amount, duration and scope of service required by a consumer. For substance abuse programs, As used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.

LICENSURE – A State or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.

LME - Local Management Entity

LOCAL BUSINESS PLAN – In the reformed MH/DD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCAL MANAGING ENTITY (LME) - The local administrative agency that plans, develops, implements and monitors services within a specified geographic area according to the terms of this Contract including the development of a full range of services and/or supports for both insured and uninsured individuals.

LOCAL QUALITY MANAGEMENT COMMITTEE – A cross system group of stakeholders including the LME, providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

MANAGEMENT REPORTS – Collections of data that are benchmarked to enable the agency to compare performance against standards and to seek continuous improvement. The reports should be comprehensive incorporating timeliness, utilization and penetration rates, customer satisfaction, functional outcomes and compliance with various standards and terms inherent in this Contract.

MEDICAID – A jointly Funded federal and State program that provides medical expense coverage to low-income individuals, certain elderly people and people with disabilities. The Federal government requires that the State/local government match the federal government funds. In North Carolina, this is approximately 60% federal/40% State/local match. People qualifying for Medicaid are “entitled” to supports and services based upon a State Medicaid Plan that is approved by the Federal Government. That Plan describes the services and benefits the individual is entitled to receive and the conditions of service provision.

MEDICAL DIRECTOR – A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system under the terms of this Contract.

MEDICAL NECESSITY - Criteria established to ensure that treatment is essential and appropriate for the condition or disorder for which the treatment is provided. The criteria reference the scope, amount and duration of service appropriate for levels of acuity and rehabilitative care.

MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with long term disabilities.

MEMBER HANDBOOK – A document developed and disseminated by the Contractor according to parameters established in this Contract to inform potential eligibles, eligibles, and enrolled persons of their rights, responsibilities and treatment coverages.

MEMORANDUM OF AGREEMENT (MOA) or MEMORANDUM OF UNDERSTANDING (MOU) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.

MH - Mental Health

MMIS - Medicaid Management Information System.

MST - Multi-Systemic Therapy

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)-A non-profit organization created to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector.

NATIONAL PRACTITIONER DATA BANK (NPDB) – A database maintained by the federal government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions that have been taken.

NATURAL AND COMMUNITY SUPPORTS - Places, things and, particularly, people who are part of our interdependent community lives and whose relationships are reciprocal in nature.

NCQA - National Council for Quality Assurance

NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.

NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OPERATIONAL AND FINANCIAL REVIEW-means the review of the Contractor conducted by DMH/DD/SAS to assess compliance with contract requirements. **OUTREACH** - Programs and activities to identify and encourage enrollment of individuals in need of MH/DD/SA services and/or to encourage people who have left service prematurely to return.

PATIENT PLACEMENT CRITERIA (PPC) - Standards of, or guidelines for, alcohol, tobacco and other drug (ATOD) abuse treatment that describe specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge / transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on ATOD diagnosis and other specific areas of patient assessment.

PCP - Person Centered Plan

PCPM – Per Citizen Per Month. The basis on which the Contractor is paid for administrative functions under the terms of some contracts.

PEER REVIEW – The analysis of clinical care by a group of that clinician’s professional colleagues. The provider’s care is generally compared to applicable standards of care, and the group’s analysis is used as a learning tool for the members of the group.

PENETRATION – The extent to which the system serves those individuals expected to have a specific medical condition, in this case persons with developmental disabilities, persons with mental illnesses and persons with substance abuse disorders.

PERFORMANCE INDICATORS - Measurable evidence of the results of activities related to particular areas of concern as indicated in this Contract. The measures are quantitative indicators of the quality of care provided that consumers, payers, regulators and others could use to compare the care or provider to other care or providers.

PERFORMANCE STANDARDS- Benchmarks an agency or provider is expected to meet. The standards define regulatory expectations and in meeting them the agency or provider may meet a required level for “certification” or “accreditation”.

PERSON-CENTERED PLANNING - A process focused on learning about an individual’s whole life, not just issues related to the person’s disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited and identifying and gaining access to supports from a variety of community resources prior to utilizing the community MHO/DD/SA system to assist the person in pursuit of the life he/she wants. Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and the services being requested from the public system to achieve the consumer’s desired outcomes. The plan is used as the basis for requesting an authorization for services. **PHYSICAL**

DEPENDENCE - A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently require the drug in order to function. If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.

PLAN OF CORRECTION – A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcomes.

PP - Primary Provider

PREVALENCE – The estimated degree of incidence of a condition in a given population.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal Prevention programs reach the general population; Selective Prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; Indicated Prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PSR - Psychosocial Rehabilitation

RESPONSIBLE CLINICIAN - An assigned professional deemed competent and credentialed by the Contractor to serve as a fixed point of accountability for the consumer’s PCP, monitoring and outreach.

PRIMARY CARE- (a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians—often referred to as primary care practitioners. (b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary. **PRIMARY SOURCE VERIFICATION** – A process through which an organization validates credentialing information from the organization that originally issued the credential to the practitioner.

PRINCIPLE DIAGNOSIS-The medical condition that is ultimately determined to have caused the consumer to seek care. The principal diagnosis is used to assign every consumer to a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PRIVILEGING – Process for determining, usually through training and supervision that an individual provider has the necessary skills and knowledge to offer designated services and can provide them without supervision.

PROMPT SERVICES - Services provided when needed. For target or priority populations, routine appointments within 14 days, initial hospital discharge visits within 3 days, urgent visits within 2 days, emergent visits immediately and no later than 24 hours **qualify as prompt.**

PROVIDER – In this Contract, a person or an agency that provides MH/DD/SA services, treatment, and supports under a subcontract to the LME.

OPERATIONS MANUAL – A document attached to a subcontract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.

PROVIDER PROFILING – The process of compiling data on individual provider patterns of practice and comparing those data with expected patterns based on national or local statistical norms. The data may include medication prescribed, hospital length of stay, size of caseload, and other services. Some data may be compiled for use by consumers in choosing preferred providers based on performance indicators.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, and commissions and boards responsible for the provision of publicly Funded services to consumers.

QA - Quality Assurance

QI - Quality Improvement

QIC - Quality Improvement Committee

QM - Quality Management

QPN - Qualified Provider Network

QUALIFIED PROVIDER NETWORK – The group of subcontractors subcontracted by a Contractor to provide supports and services to persons for whom the Contractor authorizes care.

QUALITY MANAGEMENT (QM)- The framework for assessing and improving services and supports, operations, and financial performance. Processes include: **QUALITY ASSURANCE**, and **QUALITY IMPROVEMENT**. **QUALITY IMPROVEMENT (QI)** is a process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers and administrative functions. **QUALITY ASSURANCE (QA)** involves periodic monitoring of compliance with standards.

RECOVERING STAFF - Counselors with and without educational degrees working in the substance abuse treatment fields who are in recovery.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

REGISTER – The process of gathering initial data and entering an individual into the service system.

REVENUES – Money earned through reimbursements paid for covered services or other local sources, grants, etc.

SA - Substance Abuse

SAPT - Substance Abuse Prevention and Treatment

STATE-means the State of North Carolina.

STATE PLAN- Annual (each fiscal year) updated comprehensive MH/DD/SAS systems reform plan derived from the systems reform statute and titled "Blueprint for Change".

STATE PLAN (MEDICAID)- The written agreements between the State of NC and CMS which describe how the NC DMH/DD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.

SCREENING/TRIAGE – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for services based on eligibility criteria and acuity level. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SENTINEL EVENT – CRITICAL INCIDENT, UNUSUAL INCIDENT, ETC. A sentinel event may include any type of incident that is clinically undesirable and avoidable. Sentinel events signal episodes of reduced quality of care. Many organizations monitor medication errors, review of deaths, accidents, evacuation drill responses, rights violations, medical emergencies, use of restraint or seclusion, behavior management etc. The purpose of sentinel event monitoring is to discover root causes and implement a continuous improvement process to prevent further events. **SEVERELY EMOTIONALLY DISTURBED (SED)** – A designation for people less than 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services. **SEVERELY MENTALLY ILL (SMI)** – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people with a mental illness or disorder so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities.

SERVICE MANAGEMENT – An administrative function that includes Utilization Management and Care Coordination under this Contract. The service is carried out by experienced professionals with broad knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of State facilities' bed days, making sure that networks create consumer choice in service providers.

SPECIALIST REVIEW – A consultation or second opinion rendered by a member of the UM staff when an authorization request falls outside the defined criteria for service selection, amount or duration.

STANDARD OF CARE – A diagnostic and/or treatment consensus that a clinician should follow when providing care based upon the discipline's peer group organization, such as the APA or NASW.

STATE MENTAL HEALTH AUTHORITY – The single State agency designated by each State's governor to be responsible for the administration of publicly Funded mental health programs in the State. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES PLAN – Plan for Mental Health, Developmental Disabilities and Substance Abuse Services in North Carolina. This Statewide plan forms the basis and framework for MH/DD/SA services provided across the State. **STATE OR LOCAL**

CONSUMER ADVOCATE - The individual carrying out the duties of the State Local Consumer Advocacy Program Office

SUBSTANCE ABUSE – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL GOVERNMENT

(SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) -A federal program to provide funds to States to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1 year period.

SUBCONTRACT-means any contract between the Contractor (Contractor) and a third party for the performance of all or a specified part of this Contract. The **SUBCONTRACTOR** means any third party engaged by the Contractor, in a manner conforming to the se contract requirements for the provision of all or a specified part of covered services under this Contract.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires States to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from States that fail to comply with the SYNAR Amendment.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available within the system; populations as identified in federal block grant language. *NON-TARGET POPULATION* are those individuals with less severe disorders that can be adequately and most cost effectively treated by the private sector, primary physicians or by using generic community resources.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

UM - Utilization Management

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM)- is a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. The administration of services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided. This function is carried out by professionals qualified in disciplines related to the care being authorized and requires their use of tools such as service definitions, level of care criteria, etc.

UTILIZATION-is the use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons per year, or the number of services provided per 1,000 persons by a system of care annually.

UTILIZATION REVIEW (UR)- is an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. The examination of documents and records to assure that services that were authorized were in fact provided in the right amount, duration and scope, within the time frames allotted; and that consumers benefited from the service. The review also examines whether the actual request for authorization was valid in its assessment of the consumer and the intensity of need. There are a variety of types of reviews that may occur concurrent with the care being provided, retrospectively or in some cases prospectively if there are questions about the authorization requested.